

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

3237-63-013677

FILED MAR 28 1963

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>ST. LOUIS, MISSOURI</i>		c. CITY OR TOWN <i>St. Louis</i>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>BARNES HOSPITAL</i>		d. STREET ADDRESS (If outside, give location) <i>4327 Farlin</i>	
3. NAME OF DECEASED (Type or print) First <i>LAURA</i> Middle <i>OSBORNE</i> Last		4. DATE OF DEATH Month <i>MARCH</i> Day <i>15</i> Year <i>1963</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>negro</i>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>4-21-1907</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even, if retired) <i>Domestic</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (City and state or country) <i>Angusta, Ark.</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13a. FATHER'S NAME <i>George Watson</i>		13b. MOTHER'S MAIDEN NAME <i>Mary Weatherston</i>	
14. NAME OF HUSBAND OR WIFE <i>William Osborne</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>	
16. SOCIAL SECURITY NO. <i>4200</i>		17. INFORMANT Address <i>Carrie Hickins 4320 Farlin</i>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>SUSPECTED PULMONARY EMBOLISM</i> DUE TO (b) <i>CONGESTIVE HEART FAILURE</i> DUE TO (c) <i>ARTERIOSCLEROTIC HEART DISEASE</i>		INTERVAL BETWEEN ONSET AND DEATH <i>7 days</i> <i>5 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>4200</i>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <i>1:40</i> s.m. <i>p.m.</i> Month, Day, Year <i>3/20/63</i>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <i>3/20/63</i> to <i>3/15/63</i> and last saw her/him alive on <i>3/15/63</i> Death occurred at <i>1:40 p.m.</i> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>C.D. Williams, M.D.</i> (Degree or title) M.D.		22b. ADDRESS <i>BARNES HOSPITAL</i>	
22c. DATE SIGNED <i>3/16/63</i>		23a. BURIAL, CREMATION, REMOVAL (Specify) <i>removed</i>	
23b. DATE <i>3-22-63</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Washington Park</i>	
23d. LOCATION (City, town, or county) <i>St. Louis Co.</i>		23e. STATE <i>Mo.</i>	
24. FUNERAL DIRECTOR <i>Queen Funeral Home</i>		25. DATE RECD. BY LOCAL REG. <i>MAR 19 1963</i>	
26. REGISTRAR'S SIGNATURE <i>Boad Smith, M.D.</i>			

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

INSTEAD OF

DATE AMENDED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO.

VS 300
Rev. 4/59

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Arthur L. Heilard

Licensed Embalmer No. 4221

P. O. Address 3100 Carter

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.